Introduction to the CLER National Report of Findings 2016

Thomas J. Nasca, MD, MACP

The Clinical Learning Environment Review (CLER) Program is the latest element in a progression of ACGME efforts to introduce a systems approach to improving patient safety and health care quality into graduate medical education (GME). These efforts began in 1998 with initial efforts that eventually led to the core clinical competencies—especially those relating to communication, systems-based practice, and practice-based learning and improvement.[1] In this context, attention to patient safety and health care quality has, over the past 17 years, been incorporated into the ACGME's Institutional and Program Requirements. As will be seen in this report, institutions have included these concepts in the GME curriculum in a variety of ways.

In 2009, the findings of the ACGME Duty Hours Task Force (subsequently named the ACGME Task Force on Quality of Care and Professionalism)[2] emphasized potential links between fatigue and patient safety, and noted the important role the clinical environment plays in teaching residents how to assess and mitigate risk to achieve the best possible patient outcomes. The Task Force concluded that evaluating the clinical learning environment was necessary to meet the ACGME's mission of "improving health care and population health by assessing and advancing the quality of resident physicians' education through accreditation."

Other studies have also demonstrated the need to focus on the clinical learning environment. Using a 15-year cohort study design of obstetrical care, researchers David Asch and colleagues demonstrated that the clinical site of training is an important predictor of the quality of care provided long after completion of training. Nearly one-third of the differences in patient outcomes in this study could be associated with the site of training, and these differences persisted up to 15 years after graduation from residency.[3] An American Hospital Association national survey of hospital leadership found residents and fellows who were starting their careers as independent physicians varied as to their training around systems-based practice issues such as coordinating care with other providers, working effectively with health care teams, and skills in effective communication and information exchange.[4]

The CLER Program was created to directly explore the clinical learning environment by establishing a periodic site visit program for those US hospitals, medical centers, and clinics that serve as the clinical learning environments for ACGME Sponsoring Institutions. The dimensions and attributes of this program were proposed with the advice of an ACGME-sponsored National Task Force on Patient Safety and Healthcare Quality. This Task Force recommended a site visit program that would be based on a formative evaluation model, and would not directly impact accreditation decisions; would have visits that repeated at periodic intervals in order to document change; and would involve the highest administration leadership of both the GME community and hospital, medical center, or ambulatory care site that was being visited.

At its core, the CLER Program has been designed to serve those recommendations. It is a formative evaluation distinct and separate from ACGME accreditation services, with the sole requirement that an ACGME-accredited Sponsoring Institution must periodically complete a visit to remain accredited. The decision to use a formative rather than summative approach to evaluation is built on several underlying premises. First, that there is an overwhelming degree of talent in the GME community and within our nation's clinical learning environments to help drive improvement in patient care. Second, that the GME community and the clinical learning environment leadership and staff all want to deliver the best possible care. Finally, that while standards can be used to ensure safety; standards are not the best mechanism to assist the clinical care and GME systems in each institution to strive for excellence.

"This report represents a baseline of information upon which further study will enhance our understanding of excellence in clinical learning environments."

The CLER site visits are designed as a learning tool of observation and feedback that gives clinical learning environments a means to objectively see themselves. The primary audiences for CLER feedback are the GME communities and executive leadership of the hospitals and health centers visited. The primary beneficiaries of these visits are the patients, mediated through a positive impact on the leadership and educational programs.

By aggregating these findings, the CLER Program also has the opportunity to maximize impact by providing formative feedback to the nation.

This first CLER National Report of Findings presents a cross-sectional look at the current state (2012–2015) of the six focus areas within our nation's academic teaching centers.

As noted above, the CLER Program is one element of a larger effort to inculcate principles of systems thinking, patient safety, and health care quality improvement into the physician workforce.

This report represents a baseline of information upon which further study will enhance our understanding of excellence in clinical learning environments. As such, this first set of findings reflects successes to date, and also reveals challenges and opportunities for improvement.

As you read this report you will see that much progress has been made since the release of the Institute of Medicine's (IOM) health care quality initiative that began in 1996. There are many observations in this report that reflect substantial activity around resident and fellow engagement in health care quality and patient safety activities among the nearly 300 hospitals, medical centers, and ambulatory care sites visited across the US.

"This baseline assessment provides us with an opportunity to begin to sort out which aspects of variability represent novel and important approaches to creating and maintaining an optimal clinical learning environment…"

As with any initial systematic study of complex environments, it was anticipated that hospitals and medical centers would vary in how they support clinical learning. This baseline assessment provides us with an opportunity to begin to sort out which aspects of variability represent novel and important approaches to creating and maintaining an optimal clinical learning environment and which ones may be contributing to inefficient or ineffective learning and patient care.

The observations in this initial report reveal many opportunities for continued growth. Chief among these is the pace at which GME is integrated into the institutional patient safety and health care quality efforts throughout the learning experience. It has been more than 15 years since the IOM publications, "To Err Is Human"[5] and "Crossing the Quality Chasm."[6] During the 2012-2015 period, many teaching hospitals, medical centers, and ambulatory care practices were not consistently engaging residents and fellows in the beneficial practices implemented following the IOM reports. If we are to produce physicians skilled in and able to lead quality and safety programs in their chosen specialty upon graduation, this engagement must systematically occur during their residencies and fellowships.

The report identifies a number of key findings in which there are opportunities to improve the education of our residents and fellows while at the same time improve the quality and safety of patient care.

The four overarching themes are:

- Clinical learning environments vary in their approach to and capacity for addressing patient safety and health care quality, and the degree to which they engage residents and fellows in these areas.
- Clinical learning environments vary in their approach to implementing GME. In many clinical learning environments, GME is largely developed and implemented independently of the organization's other areas of strategic planning and focus.
- Clinical learning environments vary in the extent to which they invest in continually educating, training, and integrating faculty members and program directors in the areas of health care quality, patient safety, and other systems-based initiatives.
- Clinical learning environments vary in the degree to which they coordinate and implement educational resources across the health care professions.

As a formative learning experience, the ACGME will use the findings in this report to initiate new conversations with the GME community, leaders in academic teaching hospitals and health centers, and national leaders who can inform public policy.

The ACGME will use some of the aggregated, de-identified findings to inform the accreditation process and enhance our educational offerings. We will also share this report of findings with the newly established National Collaborative for Improving the Clinical Learning Environment (NCICLE). The NCICLE was established as a forum for organizations interested in improving the quality of the clinical learning environment to exchange information and enhance their programmatic offerings to their various constituencies. Some of the initial participants in the NCICLE include the American Hospital Association, Association of American Medical Colleges, Institute for Healthcare Improvement, National Patient Safety Foundation, Association for Hospital Medical Education, Alliance of Independent Academic Medical Centers, and The Joint Commission. The number of organizations participating in this collaborative continues to increase. We anticipate that over the years, the NCICLE will be an important inter-organizational mechanism for advancing the quality of clinical learning environments for all professionals trained in our teaching institutions.

Over the first round of CLER visits, the ACGME was often asked about "best practices" for addressing GME engagement in patient safety, health care quality improvement, and the other CLER focus areas. As an accreditation organization, we resisted both a standards-driven approach and the conferring of a "best practice" status on any organization. There are still too many unknowns as to what defines a "best practice," whether a "best practice" can be sustained in its environment for any period of time, or the generalizability of a "best practice" from one clinical learning environment to another. Similarly, "one-size fits all" standards would not likely bring about innovation or local adaptation leading to excellence.

Rather than the ACGME focusing on "best practices" or standards, we have chosen to invest our efforts in working with the GME community and the leadership of their affiliated teaching hospitals, medical centers, and ambulatory care sites to discover the best path forward for GME as a whole. To that end, the ACGME, through its CLER Evaluation Committee, produced the *CLER Pathways to Excellence*.[7] This document, informed by early CLER visits, provides guidance to structures and processes that may be helpful in striving to create an optimal clinical learning environment. Recently, the ACGME also launched a national peer-to-peer learning initiative called *Pursuing Excellence in Clinical Learning Environments*. In this way the educational community can learn from one another rather than looking only to the ACGME to define direction through standards or "best practices."[8]

We believe this CLER National Report of Findings is an important next step on the journey to improving the quality of resident and fellow education and patient care. We appreciate the active participation of the GME and medical center leadership, the commitment of the program directors and faculty members, and the collaborative efforts of nursing and other professionals in the clinical learning environment. We look forward to seeing how the GME community and our nation's clinical learning environments use this report to advance their abilities to provide safe, high quality care while providing excellence in the clinical educational environment for shaping tomorrow's physician workforce.

---

[1] Swing S. ACGME launches outcomes assessment project. *JAMA*. 1998;279(18):1492.

[2] Nasca TJ, Day SH, Amis ES. The new recommendations on duty hours from the ACGME Task Force. *N Engl J Med*. 2010;363(2):e3.

[3] Asch DA, Nicholson S, Srinivas S, Herrin J, Epstein AJ. Evaluating obstetrical residency programs using patient outcomes. *JAMA*. 2009;302(12):1277–1283.

[4] Combes JR, Arespacochaga E. Lifelong learning physician competency development. American Hospital Association's Physician Leadership Forum, Chicago, IL. June 2012.

[5] Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 2000.

[6] Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

[7] The Accreditation Council for Graduate Medical Education (ACGME). CLER Pathways to Excellence: expectations for an optimal clinical learning environment to achieve safe and high quality patient care. ACGME website. https://www.acgme.org/acgmeweb/Portals/0/PDFs/CLER/CLER_Brochure.pdf. Accessed January 25, 2016.

[8] Wagner R, Weiss KB, Passiment ML, Nasca TJ. Pursuing excellence in clinical learning environments. *J Grad Med Educ*. 2016;8(1):124–127.